CASEREVIEW

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[Date notice sent to all parties]: April 23, 2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Multiple maxillary osteotomies, bilateral maxillary osteotomies, CT evaluation, waters view cephalgram

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
A Licensed Dentist with over 30 years of experience.

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

☒ Overturned (Disagree)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

PATIENT CLINICAL HISTORY [SUMMARY]:
The claimant is a female who sustained a work injury on xx/xx/xx when she fell. She subsequently underwent arthroplasty of the temporomandibular joints with partial meniscectomy in 1993. In 2000, she had undergone bilateral meniscectomy of the temporomandibular joints with placement of cryo preserved femoral head cartilage. Since then the TMJ had degenerated to the point where the claimant has a large open bit of 15 mm. The claimant is only occluding on the second molars. She has a difficult time chewing and eating and has lost 80 pound. She is currently having orthodontics to make dental adjustments prior to the surgery.

On February 7, 2013, MRI of the brain-fifth cranial nerves, Impression: 1. Markedly susceptibility and patient motion artifact degraded examination. 2. Postsurgical change from partial left parotidectomy with suspected flap reconstruction. No conspicuous enhancing mass in the region of surgery. 3. Marrow signal alteration. Exclude infiltrative disorder. 4. Indeterminate extra-axial mass overlying the lateral right frontal temporal convexity, statistically reflecting

meningioma. 5. Senescent changes without imaging evidence for acute intra-axial abnormality. 6. Left otomastoid disease.

On June 20, 2013, Maxillofacial and Temporal Bone CT, Impression: 1. Prior surgical removal of the mandibular condyles. 2. Well circumscribed density in the superficial lobe of the right parotid gland likely Iatrogenically placed device. 3. Increased density in the right parotid gland. Possibly inflammatory or post surgical in etiology. 4. Evidence of prior maxillary sinus surgery.

On October 20, 2013, wrote a preauthorization letter. Diagnoses listed: 1. Mandibular hypoplasia. 2. Absence of bilateral temporomandibular joints (TMJ). 3. Maxillary hyperplasia. 4. Severe pain. Surgical procedures necessary to correct the problems: 1. Removal right TMJ acrylic spacer. 2. Bilateral TMJ reconstruction with pure titanium total joint prostheses. 3. Bilateral TMJ fat grafts (includes harvesting grafts). 4. Construction of surgical stabilizing appliances. 5. Presurgical evaluation. 6. CT evaluation. 7. Cephalogram. 8. Panorex. 9. Waters view ceph. 10. Tomograms. 11. Hospital admission. 12. Surgery models. 13. Discharge. 14. Hospital visits.

On February 13, 2014, the claimant saw. At this time she stated she had an ear infection, but there was no drainage coming from her ear. Her bite was extremely bad and occluding only on her second molars and had an open bite of probably 15 mm. It was believed surgery was approved therefore new I-CAT and photographs were taken in preparation for the upcoming surgery. It was also noted she had an appointment with who injected some local into the left anterior vestibule.

On February 24, 2014, wrote a preauthorization letter. Diagnoses listed: 1. Mandibular hypoplasia. 2. Absence of bilateral temporomandibular joints (TMJ). 3. Maxillary hyperplasia. 4. Severe pain. Surgical procedures necessary to correct the problems: 1. Removal right TMJ acrylic spacer. 2. Bilateral TMJ reconstruction with pure titanium total joint prostheses. 3. Bilateral TMJ fat grafts (includes harvesting grafts). 4. Construction of surgical stabilizing appliances. 5. Presurgical evaluation. 6. CT evaluation. 7. Cephalogram. 8. Panorex. 9. Waters view ceph. 10. Tomograms. 11. Hospital admission. 12. Surgery models. 13. Discharge. 14. Hospital visits.

On March 6, 2014, the claimant saw. It was reported the surgery had been denied. She was reported to be in severe pain.

On September 17, 2014, the claimant saw. She was reported as status quo. She had lost 80 pounds over the last year. She was still having pain and her occlusion was still way off. Just waiting for approval of the recommended surgery.

On October 9, 2014, the claimant saw who stated she was status quo. She was complaining of significant pain issues that appeared to be muscular affecting mainly the left masseter area and some neurogenic pain. Medications included:

Valium, Lyrica, ANA, Vicodin and Tylenol. She received some adjustments from that day.

On February 3, 2015, UR. Rationale for Denial: in reviewing the information provided, it appears that bilateral TM Joint reconstruction is medically necessary. In particular, the presence of infection and only second molar occlusion would warrant this recommended treatment with the exception of the osteotomies of the maxilla and mandible. However, there has been no rationale presented to justify maxillary and mandibular osteotomies. The request for inpatient three day stay with removal of right temporomandibular acrylic space, bilateral temporomandiblar reconstruction with pure titanium total joint prostheses, bilateral temporomandiblar fat grafts, (including harvesting grafts), multiple maxillary osteotomies, bilateral mandibular osteoplasties, construction of surgical stabilizing appliances, CT evaluation, cephalogram, paneorex, waters view ceph, tomograms would be partially certified for everything but the multiple maxillary osteotomies and bilateral mandibular osteoplasties. However without a completed peer-to-peer discussion, the request cannot be certified.

On February 13, 2015, UR. Rationale for Denial: There is no conservative management at this point that will help the claimant. The imaging requested will be done prior to the surgery and is used to make the prosthetic. It is noted that the claimant has had the condition for a very long time and is progressively worsening. Regarding multiple maxillary osteotomies and bilateral mandibular osteoplasties, there is no documentation of clear rationale or additional clinical indication for multiple maxillary osteotomies and bilateral mandibular osteoplasties in the submitted medical records. Thus the requests are denied. Regarding CT evaluation, Aetna outlines diagnostic procedures for management of temporomandibular joint disorders. Literature from, states that CT examination produced excellent image for osseos morphology and pathology. In this case documentation dated 02/13/14 indicates that a new CT scan was taken on that day. There is no documentation of clear rationale for obtaining a repeat CT scan and waters view ceph are deniated.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:
The previous adverse determinations are overturned. I am recommending that the osteotomies, maxillary and mandibular, be done in conjunction with the total temporomandibular joint replacements on the right and left joints. I agree that CT scan should be taken just prior to surgery to construct the prosthetic joints to be used in the TMJ replacement, as well as the Waters view ceph. The osteotomies should be included in the surgeries for complete temporomandibular joint replacements for the following reasons: 1. states in his diagnoses that there is “Mandibular hypoplasia” and “Maxillary hyperplasia”, the osteotomies would address this discrepancy whereas the joint replacement would benefit the mandible/maxilla relationship, but it would not directly address that issue, the osteotomies would. 2. states “occluding only on her second molars and had an open bit of probably 15 mm”, again the prosthetic TMH reconstruction would aid in the open bite but would not address the open bite completely or the

overangulation of the occlusal plane that goes with the 15 mm open bite and only second molar occlusion. The osteotomies would correct this problem, thus giving the patient a chance at a better surgical outcome, occlusal function, rather than just the joint replacement. Therefore, the request for multiple maxillary osteotomies, bilateral maxillary osteotomies, CT evaluation, and waters view cephalgram are found to be medically necessary for this claimant.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ☐ **ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE**
- ☐ **AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES**
- ☐ **DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES**
- ☐ **EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN**
- ☐ **INTERQUAL CRITERIA**
- ☒ **MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- ☐ **MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**
- ☐ **MILLIMAN CARE GUIDELINES**
- ☒ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**
- ☐ **PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR**
- ☐ **TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS**
- ☐ **TEXAS TACADA GUIDELINES**
- ☐ **TMF SCREENING CRITERIA MANUAL**
- ☐ **PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**
- ☐ **OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**